Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR GROUP UNIVERSAL LIFE INSURANCE BENEFITS

SECTION TO BE COMPLETED BY METLIFE

Name of Employer	Group Report No.	Sub Division	Branch
Citi	96731 / 96973		

SECTION TO BE COMPLETED BY OWNER

Name (print) First Middle Last | Social Security No. | ☐ Male ☐ Female

Address Street City State Zip Code | Date of Birth (Mo./Day/Yr.) | Phone No.(include area code) | E-mail Address

Employee Name (print) First Middle Last | Employee SSN# | Employee Date of Hire (Mo/Day/Yr)

Reason for Enrollment: ☐ New Coverage ☐ New Hire/First Time Eligible ☐ Late Enrollee **(Statement of Health Required)**
☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other Than Coverage Amount
☐ Family Status Change Date (Mo./Day/Yr.) __________

COVERAGE REQUEST DATA:
Please refer to the Citi Summary Plan Description (SPD) or the enclosed plan overview for further Group Universal Life (GUL) plan information.
I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

For Domestic Partner coverage, you must complete and attach a Domestic Partner Affidavit or have registered as domestic partners or members of a civil union with a government agency or office where such registration is available. Check the applicable box:

☐ My Domestic Partner Affidavit has been provided to Citi Benefits Service Center.
☐ My Domestic Partner and I are registered as domestic partners or members of a civil union as stated above.

☐ **Spouse/Domestic Partner Group Universal Life Amount***
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000
Extra Monthly Contribution to the GUL Cash Fund ☐ $10 ☐ $15 ☐ $25 ☐ Other $________________

☐ **Child(ren) Term Amount*:**
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 (Note: Each child is insured for the same amount of coverage regardless of number.)

Have you smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 1 year from the date of this enrollment form?
Employee
☐ Yes ☐ No

If applying for Child(ren) coverage, complete section below:

Name(s) of Child(ren) (Last, First, MI)	Date of Birth	Sex (M/F)	Is child a full-time student?
______________	______________	_______	☐ Yes
______________	______________	_______	☐ Yes
______________	______________	_______	☐ Yes
______________	______________	_______	☐ Yes

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ADM

Please Retain a Copy of the Fully Completed Form for Your Records and Return the Original to MetLife, P. O. Box 2006, Aurora, IL 60504-2006
If You Have Any Questions, Call the MetLife Benefits Line at 1-800-523-2894

(Continued on Following Page)

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

On the date dependents insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York **[only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

Florida: **Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

Massachusetts: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.**

New Jersey: **Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

Oklahoma: **Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

Kansas, Oregon, and Vermont: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.**

Puerto Rico: **Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.**

Virginia and Washington: **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

The Owner signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from the employer. The Owner understands that he or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

Signature(s): The owner must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Owner Signature ______________________ Print Name ______________________ Date Signed (Mo./Day/Yr.) ______________________